## PATIENT REGISTRATION FORM

**DATE:**

### PERSONAL

☐ Male ☐ Female ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Separated

☐ Asian ☐ Black ☐ Latin/Hispanic ☐ Native American ☐ White ☐ Other Pacific Islander ☐ Multiethnic

| | | | |
|---|---|---|---|
| PATIENT NAME | PATIENT NAME | PREFERRED LANGUAGE | |
| D.O.B. | S.S.N. | DRIVER'S LICENSE # | |
| ADDRESS | | HOME PHONE | |
| CITY, STATE, ZIP | | MOBILE PHONE | |
| EMAIL ADDRESS | | | |
| EMERGENCY CONTACT | EMERGENCY CONTACT | PHONE | |

### EMPLOYMENT

Are you currently employed? ☐ YES ☐ NO ☐ Retired ☐ Student

| | | | |
|---|---|---|---|
| OCCUPATION | | | |
| EMPLOYER NAME | EMPLOYER NAME | POSITION | |
| EMPLOYER ADDRESS | | HOW LONG EMPLOYED? | |
| CITY, STATE, ZIP | | WORK PHONE | |

### INSURANCE

Select All That Apply: ☐ Medicare ☐ Medicaid ☐ PPO ☐ HMO ☐ Traditional ☐ None ☐ Cash Pay

| | | | |
|---|---|---|---|
| PRIMARY INSURANCE | | PHONE NUMBER(S) | |
| INSURED PARTY | PRIMARY INSURANCE | RELATIONSHIP TO PATIENT | |
| INSURANCE ADDRESS | | POLICY NUMBER | |
| CITY, STATE, ZIP | | GROUP NUMBER | |
| OTHER INSURANCE | SECONDARY INSURANCE | PHONE NUMBER(S) | |
| INSURED PARTY | | RELATIONSHIP TO PATIENT | |
| INSURANCE ADDRESS | | POLICY NUMBER | |
| CITY, STATE, ZIP | | GROUP NUMBER | |

**AUTHORIZATION TO TREAT AND PAYMENT AGREEMENT**

- I authorize examination and treatment for this and all following visits.
- I authorize to release any medical information necessary to process insurance billings.
- I authorize payment and assignment of insurance benefits to the clinic office.
- I am personally responsible for supplying accurate and current insurance information.
- I understand that payment, proof of insurance, and/or copay is due at the time of service.
- **I understand I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information.**

Grace J. Stonerock, M.D., P.C.
Family Practice

Signature of Patient or Responsible Party

Date